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**The views and experiences of suicidal children and young people of mental health support services: A meta-ethnography.**

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Abbreviated title: A meta-ethnography of suicidal young people's views of mental health services.

**Abstract:**

**Background:** Suicide is amongst the leading causes of death in young people globally and a health priority worldwide. For children and young people (CYP) attempting or considering suicide there is no agreed treatment model. Development of treatment models should be informed by the views and experiences of CYP using services.

**Methods:** Meta-ethnography was used to systematically identify and synthesise studies reporting the views of CYP who used mental health services following suicidal behaviour. Relevant studies were quality appraised. First order (participants) and second order (original author) data were translated to identify common and disconfirming themes and concepts. Translated findings were synthesised and led to a new hypothesis supported by additional 'linguistic analysis' of texts to construct a novel third

order line-of-argument. **Results:** Four studies conducted since 2006 in three countries involving 44 young people aged 11-24 years were synthesised. Translation revealed that suicidal CYP do not know where or how to access help, they cannot access help directly and when seen by mental health practitioners they do not feel listened to. Line-of-argument synthesis identified a silence around suicidality within the conversations CYP have with mental health practitioners and within academic research reporting. Use of the term 'self-harm' to encompass suicidal behaviours potentially contributes to this silence by avoiding the word 'suicide'. **Conclusions:** CYP who are suicidal need to have easy access to mental health services. When using services, they want to feel listened to and have suicidal feelings acknowledged. This involves professionals referring explicitly to suicide not just self-harm.

Word count: 250

### **Key practitioner messages**

- Children and young people (CYP) who are or have been suicidal do not know what mental health support services are available to them, or how to access them. For those who do access such services they often rely on “other” adults (including family and teachers) to refer them. There is some evidence to suggest that children and young people who are suicidal have a preference for face to face support.
- CYP who attend mental health support services in relation to suicide want to be taken seriously but do not feel listened to by practitioners.
- There is a potential silence around suicide in conversations between CYP and mental health practitioners, which is also reflected within the academic reporting of such research.
- Use of the term “self-harm” to include suicidal behavior may be contributing to this silence around suicide and could be a factor in why CYP do not feel listened to. Suicide should be discussed in conversations with CYP, not just self-harm.

**KEY WORDS:** Child; Adolescent; Suicide; Meta-ethnography; Qualitative; Synthesis

**Manuscript word count: 6611** (Including References but excluding Table: 1)

## Introduction

Suicide is one of the main causes of death in young people globally (World Health Organization, 2014) and in some countries and communities it is the leading cause of death (Appleby, et al. 2017; Ljunggren & Nickel, 2016). Reducing suicide rates in children and young people (CYP) is a major international health concern and suicide prevention is a priority for many governments worldwide (Australian Government Department of Health and Ageing, 2008; HM Government Department of Health, 2015; McLean, Maxwell, Platt, Harris, & Jepson, 2008; National Office for Suicide Prevention, 2015; New Zealand Associate Minister of Health, 2006; Scottish Government, 2013; WHO, 2017). However, there are currently no agreed treatment models and the existing evidence base for managing CYP attempting or considering suicide is limited (Hawton, et al. 2015). The support and clinical interventions delivered to this population varies locally, nationally and internationally (Hawton, Saunders, & O'Connor, 2012). Risk assessment tools for suicide have been found to offer little predictive value, meaning that the criteria for determining who is considered suicidal and when suicidal behavior warrants therapeutic intervention is subject to individual clinical judgement (Carter et al. 2017; Chan et al. 2016). It is also acknowledged that many CYP who are suicidal or self-harming do not access support services (Taylor, Hawton, Fortune, & Kapur, 2009). For example, a confidential enquiry in England found that 62% of CYP under 18yrs who had died by suicide between 2014-2015, had had no contact with Child and Adolescent Mental Health Services (CAMHS) (NCISH & University of Manchester, 2016).

There has been a broad move towards service user participation and consultation in health research (Patrick, Guyatt, & Acquadro, 2017; NHIR, 2014). Additionally, legislation regarding the rights of children to express their views, be listened to, and be involved in decisions made about them, has indicated that health services should ask CYP about their views (United Nations Convention of the Rights of the Child, 2017). These insights could then inform the

development and delivery of health services and treatment models that respond to the needs, wants and preferences of CYP (Facey, et al. 2010). In the last decade, there has been an increase in qualitative research concerned with exploring the views and experiences of children as patients in their own right (Kirk, 2007). This increase has also contributed to the growth in qualitative evidence synthesis where findings of individual studies are brought together to produce a new interpretation. It was the authors' belief that a body of relevant literature pertaining to suicidal CYPs views existed which could be synthesised to explore their views of mental health support services.

This study is the first meta-ethnography exploring the views of suicidal CYP in relation to their experiences of mental health support services to address this priority knowledge gap. Lachal, et al. (2015) in their meta-synthesis of the perspectives of young people, parents and professionals regarding suicidal behaviors, found that the violence of the suicidal act leads to incomprehension and an inability to empathise with suicidal young people. However, their review did not specifically address the suicidal young persons' views of mental health services.

## **Methods**

Although many methods of qualitative evidence synthesis exist, meta-ethnography is the most frequently cited approach (Dixon-Woods, Booth, & Sutton, 2007; Hannes & Macaitis, 2012; Ring, Jepson, & Ritchie, 2011). Meta-ethnography consists of seven phases: getting started, deciding what is relevant, reading included studies, determining how studies are related, translating studies into one another, synthesizing translations and expressing the synthesis (Noblit & Hare, 1988). Meta-ethnography was the chosen approach because it goes beyond providing a narrative or thematic review of single research studies to produce a new conceptual model or theoretical insight (Noblit & Hare, 1988). This new insight will add to current knowledge informing the design and delivery of future services for this vulnerable population. Specific review questions (phase 1) were:

- How accessible are mental health support services to CYP who have been or are suicidal?
- What are the views and experiences of suicidal CYP of the mental health support services they currently receive or have received?
- What do CYP who are or have been suicidal say that they want from mental health support services in future?

Although devised in the 1980s for use in education, developments in qualitative evidence synthesis, and specifically meta-ethnography, mean this approach is well suited to contemporary health research. A protocol for the review was registered with Prospero (CRD42017071126).

Searching for qualitative literature (phase 2) is generally problematic (Evans, 2002) and triangulation of search methods is advised (Shaw, et al. 2004). Specific challenges associated with defining the search criteria for this review included the lack of an internationally agreed definition of adolescence meaning that papers addressing this population can have an upper age range of 18 to 25 years. Additionally, as definitions of self-harm can include suicidal behavior, the term suicide is not always used in article titles. This review used a broad definition of suicidal to include suicidal behavior (any act of self-harm intended to end ones' life whether fatal or non-fatal) and suicidal ideation (thinking about ending ones' life including the planning of suicidal behavior).

These factors were considered when devising our inclusion and exclusion criteria. For example, the age range was set as broadly as possible to ensure all potential studies were captured, and although self-harm was not used as a search term, papers that used this term were screened for relevance. Broad based, thesaurus and free text approaches were used to systematically search (first author, LG) CINAHL, Medline, PubMed, Child Development and Adolescent Studies, and Psych-Info between June and July 2017 using the search terms shown in Box 1.

The reference lists of potential studies were also screened. An internet search of relevant national and international organisations with interests in this area (CYP and their health and wellbeing) was conducted to identify potential grey literature such as research reports.

<b>Box 1: Electronic database search terms</b>	
<b>Search 1</b>	<b>Search 2</b>
child*, young, adolesc*, teen*	child*, young, adolesc*, teen*
suicid*	suicid*
CAMH*, mental health, psychiat*	view*, experienc* opinion* percep*, belie*,
view*, experienc* opinion* percep*, belie*,	feel*, know*, understand*
feel*, know*, understand*	qualitative, mixed method*
qualitative, mixed method*	interview, focus group, questionnaire*
interview, focus group, questionnaire*	

Due to concerns that preliminary searches (Search 1) may have been too specific, searches were then re-run but without the terms relating to 'mental health services' (Search 2) to make the search more inclusive. Search results (see Supplementary Table 1) from both searches were combined and reported using PRISMA (Diagram 1) (Moher, et al., 2015). Titles and abstracts of possible studies were initially screened (LG) against the inclusion criteria (Box 2). Articles were limited to English language publications as there were no funds for translation and papers published before 2000 were excluded as they could be considered unlikely to reflect contemporary practice.



**Box 2: Inclusion and exclusion criteria***Inclusion criteria:*

- Studies in English published after 2000.
- Sample population of children and young people (CYP) aged between 5 and 25 years (inclusive).
- Studies reporting views and experiences of CYP who have used mental health support services for suicidality or self-harm including suicidality.
- Primary reports of studies using qualitative approaches and methods e.g. grounded theory, interviews and focus groups, including mixed methods studies.

*Exclusion criteria:*

- Studies not in English, published pre-2000.
- Studies where most participants were aged under 5 years or over 25 years.
- Studies reporting views and experiences of CYP who have used mental health support services for reasons other than for suicidality or self-harm including suicidal intent or where data relating to CYP and suicidality were not explicitly reported and could not be independently extracted.
- Studies reporting other views and experiences e.g. CYP attempting suicide, preventing suicide in CYP, parents bereaved by suicide, professionals' views of delivering services or CYP use of other services e.g. GP care.
- Not primary qualitative research reports e.g. qualitative evidence syntheses, reviews, narrative reports or editorials.

The full text of studies meeting the eligibility criteria were screened independently by all authors and disagreements resolved through discussion. It was agreed that four studies (Idenfors,

Kullgren, & Renberg, 2015; McAndrew & Warne, 2014; Murray & Wright, 2006; Wadman, et al. 2017) met the criteria for inclusion in the synthesis. (Reasons for exclusions are provided in Supplementary Table 2). Although not a pre-requisite in meta-ethnography, all included studies were quality appraised (Critical Appraisal Skills Programme (CASP), 2017) by first author (LG), and were found to be of either “good” or “high” quality (Supplementary Table 3). This systematic appraisal supported the essential close reading of included texts required in phase 3.

**[Insert Diagram 1 here]**

Data extraction (phase 3) (LG and checked for accuracy by NR & MM) initially involved extracting characteristics of included studies, such as participants and study context, into a predetermined template (Table 1). First and second order data (respectively original participant quotes and original author interpretations (Noblit & Hare, 1988)) were then extracted verbatim for each study, imported into NVivo, and descriptively coded line-by-line using the review questions as an a priori coding frame (LG). Included studies were related (phase 4) through their characteristics and first and second order data. Translation of included studies (phase 5) was a) reciprocal - through identification of shared themes, concepts and metaphors and b) refutational - by identification of disconfirming cases (Noblit & Hare, 1988). Translation was a complex iterative process involving constant comparison between studies and development of concept maps to create a new line-of-argument. Translation enabled findings to be synthesised into a third order, over-arching reviewer interpretation, going beyond simple narrative reporting of original themes (Noblit & Hare, 1988). LG led the translation and synthesis process, supported by NR and MM. The recently developed meta-ethnography reporting guidance (eMERGE), devised to enhance the transparency and quality of reports (France, Cunningham & Ring, et al, 2019), informed our reporting and full details of our methods are shown in Supplementary Table 4.

## **Findings**

Four papers reporting four separate studies were translated and synthesised (Idenfors, Kullgren, & Renberg, 2015; McAndrew & Warne, 2014; Murray & Wright, 2006; Wadman, et al. 2017) (see Diagram 1). These studies were conducted in the UK, Canada and Sweden in various health settings between 2006 and 2017 with 44 participants aged between 11-24 years (Table 1). Three studies included children under 16 years (McAndrew & Warne, 2014; Murray & Wright, 2006; Wadman, et al. 2017). Study participants ranged from three (Murray & Wright, 2006) to 24 (Wadman et al., 2017). Participants were predominantly female. Only one study described participant ethnicity (McAndrew & Warne, 2014). One study was concerned solely with a suicidal population (Murray & Wright, 2006). McAndrews and Warne's (2014) participants had experience of self-harm or suicidal behavior. Idenfors, et al. (2015) recruited those with a history of self-harming behavior but asked participants about their knowledge of where to go for help during a suicidal crisis. Wadman, et al. (2017) focused exclusively on self-harming CYP who were 'looked after and accommodated' by social work services but used a definition of self-harm to include suicidal intent. All four studies used interviews for data collection.

**[Insert Table 1 here]**

Included papers were reciprocally translated against the review questions as follows:

### **Challenges accessing mental health support services**

Translation of first (Idenfors, et al. 2015; McAndrews & Warne, 2014) and second order data (Idenfors, et al. 2015; McAndrews & Warne, 2014) revealed that CYP found services difficult to access; not knowing where, or how to access help, and being frustrated at not being able to access services directly themselves. For example:

*“I did not have a clue in the slightest, I didn’t know there was [a] Child and Adolescent Mental Health Service (CAHMs) (Fiona)” (McAndrews & Warne, 2014:575).*

Accessing services was complicated, and often involved young people being signposted to other services or re-referred to services that had not met the needs the first time.

*“... I didn’t think that they could help me. So, I didn’t really trust them. But then I called the mobile team here, a while ago. But then they sent me to the young adult health center. And then I gave it up again (Participant 7)” (Idenfors, et al, 2015:182).*

Both Idenfors, et al. (2015) and Murray & Wright (2006) identified that having immediate access to help is an important issue. For example:

*“Just the fact that I know that I did not come directly to the child and adolescent psychiatry clinic. And that alone is probably difficult, I think. That there isn’t a direct number. (Participant 3)” (Idenfors, et al., 2015:181).*

CYP participants relied on others, usually friends, family and teachers (Idenfors, et al. 2015; McAndrews & Warne, 2014) to facilitate referrals to mental health services. Wadman, et al. (2017) noted that the removal of ‘looked after and accommodated’ children from these generic support networks may impact negatively on their mental health (Wadman, et al, 2017). Given that CYP rely on other adults to make referrals to support services on their behalf, being taken seriously and feeling supported by these adults could be the difference between them going on to access services or not. McAndrews & Warne (2014: 574-575) highlighted that the support CYP received in school was not always appropriate, for example:

*“...it was brushed off (Nina)” and “I did tell them I was depressed and I had these suicidal thoughts, ... but she never said anything (Julie)”.*

Primary data in Idenfors, et al. (2015); McAndrews & Warne (2014) and Wadman, et al. (2017) tells us that another barrier to accessing support services was CYP not being able to talk about thoughts and feelings. For some this stemmed from fear of being judged and lacking trust in services. *“I was thinking, what will he [general practitioner] think, if I was going to be judged, which put me off going (Kim)”* (McAndrews & Warne, 2014:573). Feeling embarrassed or feeling that their issues were insignificant were other reasons participants reported for not wanting to get help.

Translations based on second order constructs across the studies (Idenfors, et al. 2015; McAndrews & Warne, 2014; Murray & Wright, 2004; Wadman, et al. 2017) reflected the primary data. That is, CYP not wanting or feeling able to talk because they have no trust in services, feelings of shame and perceptions of stigma associated with their suicidal and self-harming behaviours, fear of being judged, and fear of the consequences of disclosure. Idenfors, et al. (2015) refers to attitudinal barriers to help seeking which were identified amongst the young people. Idenfors, et al. (2015) and Wadman, et al. (2107) also identified that many CYP believed that they should help themselves.

### **Experiences of mental health support services**

Reciprocal translation also revealed that when CYP managed to access mental health support services their experiences were variable – a *“mixed bag”* according to Wadman, et al. (2017). Idenfors, et al. (2015) reported that the profession of the person delivering the service is less important to the CYP than being able to get on with them. Positive experiences of care across the studies were ascribed to how the person (professional) made them feel.

*“...he also took it seriously immediately ...” (Participant 6)”* (Idenfors, et al. 2015: 182).

*“she (specialist nurse) was easy to talk to ...”* (Murray & Wright, 2006: 160).

*“she went out of her way to make me feel comfortable, and I never felt like I was talking to a professional, she’d always make me feel like she was, like she was really, she was so good” (ID 29)” (Wadman, et al. 2017: 9).*

*“because of his (CAMHS counsellor) attitude, it kind of made me realise that it wasn’t necessarily talking to a stranger about my problems, it was talking to someone who could help me, that’s the difference (Fiona)” (McAndrews & Warne, 2015: 574).*

However, these positive experiences were not, as strongly reflected in the data across all the papers. Two studies (Idenfors, et al. 2017; Wadman, 2017) reported that CYP talked about not being listened to, being patronized, and that therapists/workers failed to engage with them regarding their worries. Therapists/workers often imposed their expert opinion upon what they believed CYPs problems to be, rather than listening to what was being said. For example:

*“...the lady I was talking to was, she was nice, but she was incredibly patronizing.”*  
(Wadman, et al. 2017: 8)

*“...she doesn’t listen to what I say...I don’t know she twists things I say to ... I don’t know how to explain it it’s like nothing I say is important” (Wadman, et al. 2017: 8).*

*“Negative experiences included medication prescribed for depression or anxiety that did not work well, or a regular contact that did not help” (Idenfors, et al., 2015:182).*

Original author interpretations of these negative experiences did not go further than describing what they had heard from participants and are therefore generally reflective of the first order constructs reported above. But, together they suggest a bleak picture of how this vulnerable population of CYP feels about how they are dealt with by mental health support services.

## **What CYP say they want from support service**

The CYP who participated in these studies had a strong sense of what they wanted from a service; primarily someone to listen to them and treat them with respect. Participants in all studies reported that successful engagement with services was attributable to the individual workers that they met and how they were treated by them.

*“I had very high standards for people...if they looked down on me or said something that made me mad, just something a bit off beat, it would completely ruin it. I’d want to leave. I never wanted to go see somebody and I never wanted to make it feel like they were just there to do their job, and they were getting paid for what they were doing, and they never gave a shit outside of it,”* (Murray & Wright, 2006: 161)

*“But then I began to understand that maybe the problem isn’t that the help doesn’t work, but it’s that you have to meet the right person, quite simply (Participant 3)”* (Idenfors, et al, 2015: 182).

Although CYP wanted different ways to directly access services, such as by telephone or in person (Idenfors, et al, 2015), most wanted face-to-face contact (McAndrews & Warne, 2014) with someone who listens and takes them seriously (Idenfors, et al 2015). There was only one reference to a young person who wanted on-line support (McAndrews & Warne 2014) and one other expressing a preference to initial email contact (Idenfors, et al. 2015).

Murray and Wright (2006) stressed the importance of connection and communication with suicidal CYP, identifying these as themes and highlighting the significance of workers applying a “needs led” approach, including actively listening and allowing the CYP to express themselves freely. Idenfors, et al. (2015) discussed that problems in making/maintaining relationships is often a key issue for suicidal CYP. They go on to suggest workers should not dismiss what CYP have to say, and should demonstrate empathy and active listening in their contacts with them.

Wadman, et al (2017), note how difficult it was for the 'looked after' children in their sample to talk about their feelings and experiences. They propose this was not because these children did not want to talk, but was understandably related to their lack of trust in general in helping agencies, and their trauma histories. The authors advocated that healthcare workers need to demonstrate increased levels of compassion in order to form collaborative relationships with these CYP (Wadman, et al 2017). McAndrews and Warne's (2014) described what they considered to be helpful professional characteristics based on their participant accounts such as: listening, being non-judgemental, allowing the CYP to talk, offering confidentiality, and being trustworthy.

The four studies in this synthesis were conducted in three countries and all were contextually different in their settings (Table 1), and yet, reciprocal translations of the experiences of these CYP were markedly similar in terms of the concepts, themes and metaphors. For example, Wadman, et al's (2017) study focused solely on looked after and accommodated children but despite this group of CYP being different in terms of where they lived and their increased vulnerability, first order participant data from these studies showed that looked after CYP want and need the same things from mental health support services as the broader population of self-harming and suicidal CYP who live at home.

However, one key difference was noted between studies and refutational translation was possible. Murray and Wright's (2006) Canadian study stood out as different in terms of the positivity of respondents to their experience of mental health services. These young participants were engaged in a pilot of a new suicide risk assessment model which emphasized their social context. This was the smallest study (n=3) and those with negative experiences may not have come forward for interview. Nevertheless, the descriptions of the specialist nurse actively listening and taking these CYP seriously also supports what participants in the other papers



reported as wanting from services (Idenfors, et al. 2015; McAndrews and Warne, 2014; Wadman, et al. 2017).

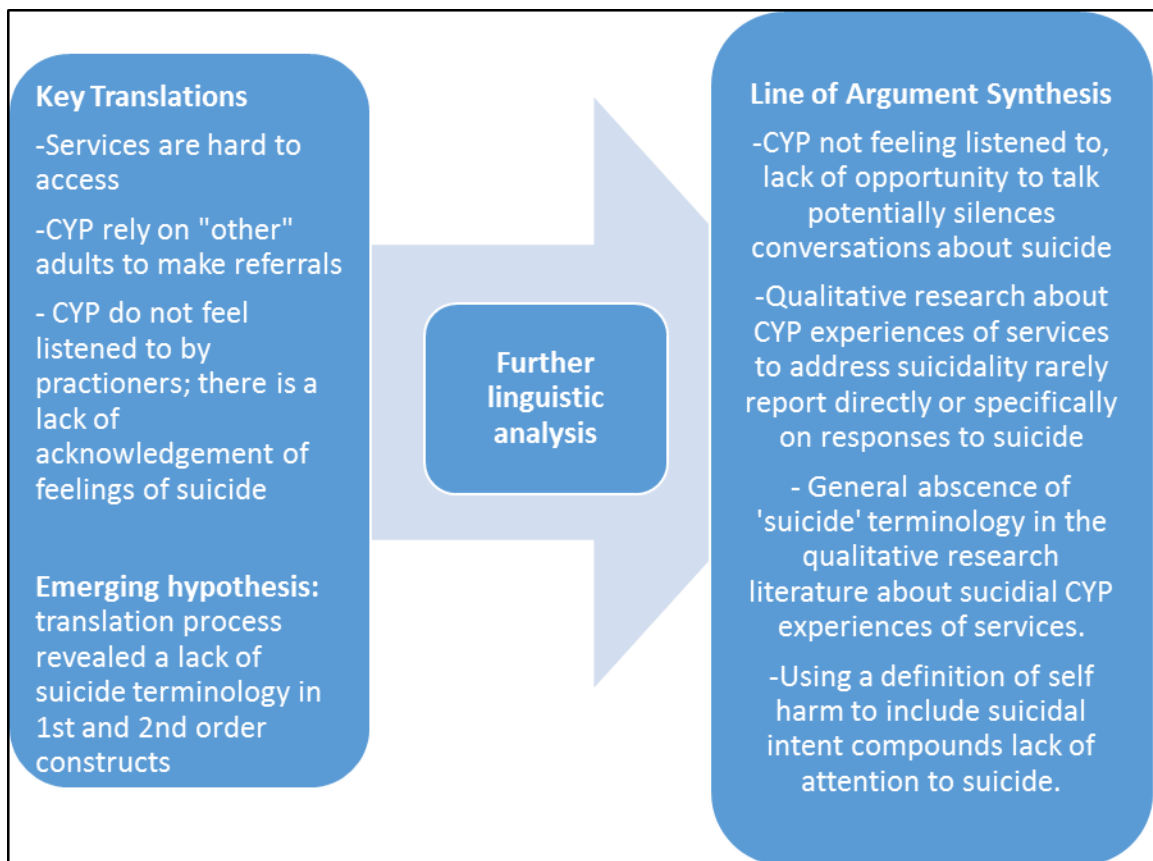
### **Line-of-argument synthesis**

Through deep immersion within the narrative of these studies and their translations an unexpected finding emerged - there was a distinct lack of discourse about 'suicide' within their content. This was confirmed through linguistic analysis (Biber, Conrad, & Reppen, 1998) which identified the frequency with which 'suicide', 'suicidal' and 'suicidality' appeared within these texts, where and in what context (Supplementary Table 5). This revealed, for example, that these words appeared in the title of only one paper, and as 'key words' in two. Whilst all four papers referred to suicide/suicidal in their introductory sections, such terms only appeared in participant findings in two papers (Murray & Wright, (2006); McAndrews & Warne (2014)). Suicide/suicidal was mostly used in a contextual manner or as a general reference to 'suicide risk assessment', 'youth suicide ideation', 'suicidal crisis', 'suicidal communication', 'suicidal behavior' or 'suicide pathway' (Murray & Wright, 2006; McAndrews & Warne (2014); Idenfors, et al. (2015). Three papers referred to suicide/suicidal in their discussion but only one did so in a discursive manner (McAndrews & Warne, 2014) (Supplementary Table 5). No paper used these terms in their conclusions. Across the papers, references to suicide in the context of the thoughts or behaviours of the CYP themselves were rare. Only four CYP participants in two papers (McAndrews & Warne 2014; Murray & Wright 2006) were quoted as referring to their own suicidality and one paper (Murray & Wright 2006) reported that a parent declined consent for their child to be interviewed because they did not want them talking about their suicidal experience (Supplementary Table 5). Linguistic analysis revealed that references to suicide/suicidal in these papers were mostly used in a descriptive context such as referring to study populations, defining self-harm or treatment processes. Overall, there was a lack of reference to suicide/suicidal by the CYP within these studies.

Our new line-of-argument synthesis (Figure 1) is that metaphorically, this is potentially what happens with the suicidal concerns of CYP – they remain hidden and un-addressed. Even though self-harm is a strong precursor for suicide, there was a silence around suicide within the conversations the CYP participants reported having with practitioners, and this has also been reflected within these reporting of this research. The relative absence of suicide terminology in the clinical conversations reported, and limited reference to suicide/suicidal in the findings and discussions of these papers, reflects the current dominance of the self-harm discourse. The use of self-harm as an umbrella term to refer to all self-harming behavior, including suicidal intent, can result in suicide being ‘lost’ in clinical conversations and research narratives. Self-harm as a prolific term which can encompass suicidal intention, intensifies the focus of risk around self-harm but also helps create and maintain a silence around suicide. If this general lack of direct reference to suicide (as found in these research reports) is followed through into professional practice, then it may be that this silence is contributing to CYP not feeling listened to or believed when they do disclose this information to mental health support services.

A possible impact of this silence could be increased risk of suicide, which resonates with the findings in some of the included studies. For example, when McAndrews and Warne (2014: p576) reported these CYP as: *“not being able to talk about problems [which] might in turn exacerbate feeling alone, a situation having the potential to lead to suicidal ideation”*. Similarly, in the case of a young man described by Idenfors, et al. (2015: p182) who was reported to have taken an overdose after being re-referred to a service that he did not believe helped him first time around.

*Figure 1: Key Translations and Line of Argument Synthesis: potential to silence suicide in children and young people.*



## Discussion

It is known that CYP experiencing mental health problems have difficulties accessing services (Gulliver, Griffiths & Christensen, 2010), and that most CYP who self-harm do not access support (Chandler, 2017). Our findings offer insight into why this may be so from the perspective of suicidal young people, in particular, highlighting the existence of internal and external barriers to CYP seeking help for suicidality. Internal barriers are those associated with their presenting mood and condition, such as not wanting to talk, feelings of shame, fear about what other people might think and the CYP's own perceptions of the stigma associated with accessing mental health support. External barriers include CYP not knowing where to access help, and the

complex 'revolving door' process experienced by CYP accessing services (including poor signposting and the need for re-referral) in which they had to rely on others to access these services for them. Not only do CYP experience barriers in initially accessing mental health support services, once they get referred they can experience further barriers within these systems, such as not feeling listened to or understood by practitioners.

Some positive aspects of mental health support services for these CYP were reported by participants such as; the use of a new risk assessment model that emphasised young people's social context (Murray & Wright, 2006) and the benefits to CYP of meeting staff who they felt empathised with them. However, in general, the views and experiences of CYP presenting with suicidality indicated that the services they received were not adequately meeting their needs and there was an urgent requirement to improve these services.

It should also be noted that despite recent calls to further develop the potential of on-line resources, there was some data to suggest that children who have been, or are suicidal prefer face to face support (McAndrews & Warne, 2014). The importance of connecting with real people is reflected in the wider suicidology literature (Lakeman, 2010).

The need to hear the voices of children with complex mental health issues has been recognised generally (Hart & O'Reilly, 2017) and specifically in the context of suicide (Bergmans, et al. 2009; NSPCC, 2014). There is a need for healthcare practitioners to listen to the views of suicidal children when delivering care (Montreuil, Butler, Stachura, & Pugnaire Gros, 2015). However, our line-of-argument synthesis is novel, enabling a more nuanced understanding of such issues by suggesting there is a potential to silence the subject of suicide in clinical conversations when young people do not feel listened to. Our meta-ethnography has also revealed further original insight by highlighting other factors that undermine or unintentionally silence the issue of suicide in CYP for example, the lack of exploration or references to suicide by academic authors conducting and reporting research in this field (Supplementary Table 5).

Despite suicide in CYP being an international concern, it was also difficult to find studies reporting their views and experiences, for inclusion in this review. The use of the umbrella term 'self-harm' to include suicidal behavior within the literature contributed to this but it was also because some studies which included child and adult participants did not report data separately for these two groups, resulting in the voices of suicidal young people being lost within the overall reporting of data.

The voices of specifically vulnerable and at-risk groups were also notably absent from the included papers. Suicidal CYP are a hard to reach population, and relying on the accounts of those represented in these studies (largely white female populations) excludes the experiences of those most at risk of suicide that is, males and marginalised groups (such as young black males, indigenous populations and LGBT young people) (AFSP, 2018; Appleby, et al. 2016; Australian Government Department of Health, 2013; King, et al. 2008; McKenzie, Serfaty, & Crawford, 2003; NCISH & University of Manchester, 2016; Sàmi Norwegian National Advisory Unit on Mental Health and Substance Abuse & The Saami Council, 2017). This could be yet another level on which CYP who are suicidal are silenced when those most at risk are not included in research studies.

Finally, the findings of our meta-ethnography suggests that silence around suicide may also extend to conversations between CYP and their parents or in parental attitudes as illustrated by parents declining consent to their children taking part in research saying, *'my child is doing very well now and I do not want to bring back their suicidal thoughts and behaviors by talking about their experience'* (Murray & Wright, 2006: 159). The UK charity ChildLine has also reported that for many of the children contacting its helpline, their parents had declined to have any further discussion with them on the topic or tried to change the subject (NSPCC, 2014: 24).

Overall, this potential parental, practitioner and academic silence around suicide in children is an issue that warrants further investigation. It may be that there is some difficulty in

comprehending or acknowledging suicide in CYP and self-harm is somehow easier to deal with. It may be that there are fears that talking about suicide may contribute to more suicidal thoughts and behaviours by CYP. The reasons behind parental silence may be different from those of professionals or academics, and therefore more research is needed to understand these phenomena from different perspectives.

### **Practice implications**

Mental health support services for use by CYP with suicidal behaviour and ideation need to become more easily accessible for this population. Consideration should be given to providing services that CYP themselves can directly access and which encourage access by marginalized groups; remaining mindful that there is some evidence to suggest that children and young people prefer face to face support.

Practitioners need to be aware of, and address, barriers during their consultations such as CYP not feeling respected or listened to and be aware of the potential to silence suicide in clinical conversations (and research), especially when they may miss dealing with the risk of suicide by exclusively adopting the language of self-harm.

### **Limitations**

Identifying literature that solely addressed suicidality in CYP is made more difficult because self-harm definitions can incorporate suicidal behavior. Our electronic search focused specifically upon suicide and this may have limited the number of studies that we were able to include because we did not purposively search for studies that used self-harm terminology to include suicidal behaviors. There is a significant volume of self-harm literature. To identify the views of CYP who were suicidal within those who studies self-harm within studies that combined suicide within the term 'self-harm' would have required substantial resources that were beyond the

scope of this unfunded study. However, our study highlights the scarcity of literature specifically addressing the views of suicidal CYP in relation to mental health services. A further limitation to our search criteria was that we were only able to include those studies published in English and which were accessible in our timescales.

The included studies did not fully describe the gender identity, ethnicity or socio-economic status of their participants – the ethnicity of participants was only stated in one study. The participants in all of these studies were disproportionately female and living in Europe, therefore our findings may have limited transferability to other more vulnerable groups.

Studies included in the meta-ethnography were conducted in three different countries. However, despite international differences in service provision, their findings shared many similarities such as these CYP needing to know where to access help themselves and the importance of needing staff who understood them and they can connect with (Table 1).

The purpose of a meta-ethnography is to elicit new theories / understandings and this can be achieved with a small number of studies, what is critical is the conceptual richness of the data as this is essential for translation and synthesis (phases 5-6) (Noblit & Hare, 1988). Data extraction confirmed that all four studies reported data of the necessary depth required for translation and synthesis. However, our line of argument, as with any new theory arising in this way requires testing through further research.

## **Conclusion**

This is the first meta-ethnography of studies reporting the views and experiences of CYP who have used mental health support services for suicidal behaviors. As such it breaks new ground and provides novel insight into mental health support services from the perspective of suicidal young people who have been, or are, using these services. There are both internal and external barriers to CYP accessing mental health services for suicidal behaviour. Children and young

people who are suicidal need to be aware of and have easy access to mental health services. When using these services, they want to feel listened to and have their suicidal feelings acknowledged. This involves professionals referring explicitly to suicide and not just self-harm. There is a potential silence around suicide in conversations between CYP and mental health practitioners. Research in the field may also perpetuate this silence, especially when researchers do not differentiate between suicidal and self-harming populations.

Future research is needed to investigate and ascertain these translated findings and new line-of-argument from the perspective of a larger number of CYP participants especially those from marginalized groups at greater risk of suicide. There is also a need to explore our findings from the perspectives of the practitioners involved in delivering mental health services, and potentially researchers in the field.

### **Acknowledgements**

LG is an ESRC funded PhD student. No other funding was received for this study. All authors contributed to the study design and conduct. LG led on all stages with NR and MM cross-validating and contributing to the translation and synthesis process. The authors declare they have no competing or potential conflicts of interest. All authors contributed to writing of the paper.

### **Supporting Information**

Supplementary Table 1: Search histories and outcomes.

Supplementary Table 2: Reasons for exclusion of articles read in full text.

Supplementary Table 3: CASP Quality Appraisal results.

Supplementary Table 4: Details of methods as informed by the eMERGE meta-ethnography reporting guidance.



Supplementary Table 5: Linguistic analysis of references to suicide and suicidal in the narrative of included studies.

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Diagram 1: PRISMA (Moher et al., 2015)

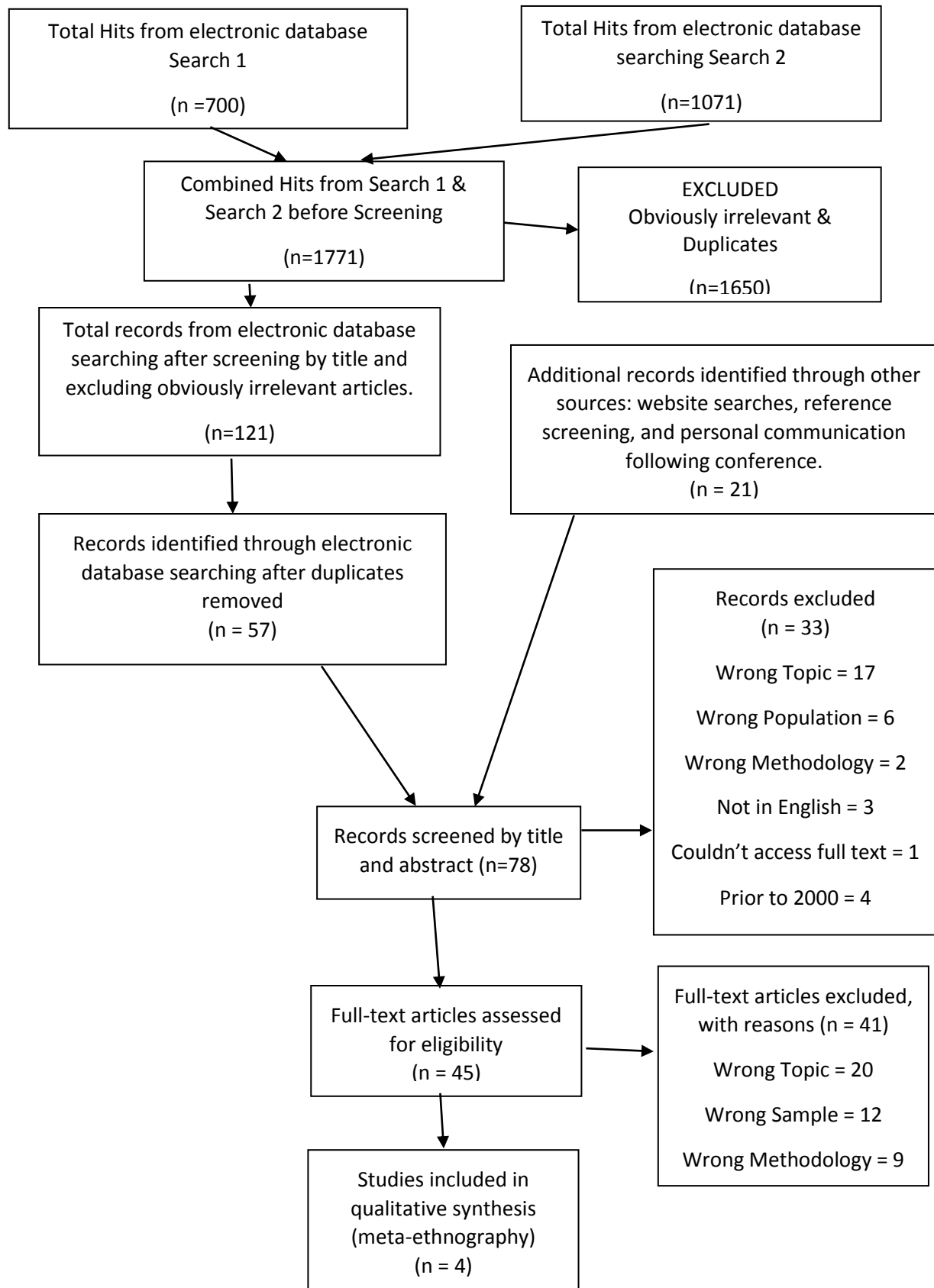


Table 1: characteristics of included studies

Authors & Year	Sample	Context	Methods	Key findings
Murray, B. L; Wright, K.  2006	<p>n=3 14, 18 &amp; 19 years. Male =2; Female =1 Ethnicity: Not described.</p> <p>Participants had participated in a suicide risk assessment interview by the 1<sup>st</sup> author (at least 1.5 years before), had completed treatment and were stable. Small sample reflects that recruitment was difficult as parents were reluctant to consent for fear it would bring back feelings of suicide.</p>	<p>Saskatchewan, Canada.</p> <p>Mental Health Youth Services.</p> <p>Study team: Clinical Nurse Specialist and a Registered Doctoral Psychologist (2<sup>nd</sup> author).</p> <p>Study aim: Convey the perspectives of young people who had experienced a new approach to suicide risk assessment.</p>	<p>Phenomenological analysis</p> <p>In-depth interviews in interviewer's office.</p> <p>Interviews conducted by 2<sup>nd</sup> author who had no relationship with participants</p> <p>Parents were also involved in interviews as this was part of a larger study, relating to a new model of suicide risk assessment, with parents' perspectives reported elsewhere.</p>	<p><i>Themes from 1<sup>st</sup> order participant data:</i></p> <p>YP spoke of fear, anxiety, and shame after being referred for suicide risk assessment; the importance of a quick referral process, immediate help and having one therapist over a consistent period to establish trust in their relationship with the practitioner.</p> <p>Change - Three different aspects were reported after the assessment process: change in their thinking, other intrapersonal changes &amp; a change in interpersonal relationships.</p> <p>Hope – that things could or would change and how they shifted from a sense of giving up hope to hopefulness. Recognition of their own ability to deal with their problems/issues and the importance of not feeling alone.</p> <p>Connection – the importance of the connection to the clinical nurse specialist and the importance of feeling that someone cared for them.</p> <p><i>Themes form 2nd order author interpretation:</i></p> <p>Connection: establishing a meaningful relationship with adolescents – connecting and engaging with them. This needs genuine interest, time, establishing and maintaining a trusting relationship.</p> <p>Communication: requires active listening to</p>

Authors & Year	Sample	Context	Methods	Key findings
				<p>understand the meaning behind their stories or conversations, a non-blaming and non-judgemental approach.</p> <p>Context: practitioners need to understand YP and their behaviour in context e.g. of their peer group.</p> <p>Co-operation: e.g. focusing on the YP strengths to promote a shift away from their challenging behaviour towards one of participation and co-operation.</p>
McAndrew,S.; Warne,T.  2014	<p>n=7 13-17 years Male =0; Female =7 Ethnicity: White British.</p> <p>Purposive sample of CYP who had experience of self-harm and/or suicidal behaviour.</p>	<p>UK – North of England.</p> <p>Study team: 2 academics from a university School of Nursing &amp; Social Work. Team included a mental health nurse.</p> <p>Study commissioned by Child Death Overview Panel and Safeguarding Children Board.</p> <p>Study aim: to present narratives of YP with self-harming and or suicidal behavior, to identify how services can best meet their needs.</p>	<p>Interpretive phenomenology analysis.</p> <p>1-1 interviews at venues to suit participants.</p>	<p><i>Themes from 1<sup>st</sup> order participant data:</i></p> <ol style="list-style-type: none"> <li>1. Cutting out the stress e.g. triggers of self-harm</li> <li>2. Stepping onto the path of help e.g. deciding to access help</li> <li>3. Cutting to the chase: prioritising self-harm on the public agenda e.g. knowing who can help.</li> </ol> <p><i>Themes form 2nd order author interpretation:</i></p> <ul style="list-style-type: none"> <li>-Many things trigger self-harm, and YP often use self-harm as a way of coping</li> <li>- YP experience feelings of shame associated with their SH behaviour.</li> <li>-YP find it difficult to identify who they should talk to about their self-harming or suicidal behaviour.</li> <li>- Young People identify that they prefer face to face contact, with someone independent from family and friends, who displays a non-judgmental attitude, listens and is someone they</li> </ul>



Authors & Year	Sample	Context	Methods	Key findings
				<p>can trust.</p> <p>-Schools are well placed to support CYP around the onset of self-harm.</p> <p>-YP want more information about self-harm and where to access help.</p>
<p>Idenfors,H; Kullgren,G; Salander-Renberg, E.</p> <p>2015</p>	<p>n=10 17-24 years Male =4; Female =6 Ethnicity not described.</p> <p>Young people presenting with deliberate self-harm at hospital. Did not distinguish suicidal behaviour, form Non-suicidal self-injury. Recruited from various departments including emergency, child &amp; adolescent psychiatry.</p>	<p>Northern Sweden</p> <p>Hospital based and community psychiatric services.</p> <p>Study team: First author: male; resident in psychiatry but with no relationship / responsibility for the patient participants.</p> <p>Study aim: Explore the views of CYP who had attempted suicide or self-harmed before contacting services, eliciting what affected their decision to establish contact.</p>	<p>Semi-structured interviews at a location chosen by interviewee</p> <p>Data collected 2009-2011</p>	<p><i>Themes from 1<sup>st</sup> order participant data:</i></p> <p>Suicidal Children and Young People (CYP):</p> <p>-lack knowledge about where to turn for help.</p> <p>-need many possible routes to professional care.</p> <p>-[state] the importance of immediate help</p> <p>-[state] the importance of family and friends when over-whelmed by emotional storms.</p> <p>-[state] the importance of quality of contacts.</p> <p>-perceive one should not communicate distress.</p> <p><i>Themes from 2<sup>nd</sup> order author interpretation:</i></p> <p>-There is a need for more flexible, available, and varied health care.</p> <p>-Suicidal CYP struggle between wanting to be independent and needing reliable support.</p> <p>-Contact with CYP that are suicidal should be empathic and demonstrable active listening.</p> <p>-Involvement of family and friends is crucial and might be pivotal in supporting access to services.</p>
<p>Wadman, R, Armstrong, M, Clarke, D, Harroe, C, Majumder, P, Sayal, K, Vostanis, P, Townsend, E</p> <p>2017</p>	<p>n=24. 14-21 years Male =4; Female =20. Ethnicity: not described.</p> <p>All were looked after CYP or recent care leavers who had self-</p>	<p>UK – East Midlands</p> <p>Participants had all been looked after and accommodated.</p> <p>Study team: multi-disciplinary; included professionals from</p>	<p>Interpretative phenomenological analysis.</p> <p>Semi-structured interviews in various locations. Interviewer from a research not clinical background.</p> <p>Emotional rating scales completed before and after</p>	<p><i>Themes from 1<sup>st</sup> order participant data:</i></p> <p>-Changes in placement are perceived as highly relevant to SH either as a cause or consequence.</p> <p>-Feelings of anger (and turning anger on self).</p> <p>-Not wanting to talk; not feeling able to talk.</p> <p>- developing their own coping techniques to deal with SH.</p> <p>-experience of clinical services: a relational mixed bag.</p>

Authors & Year	Sample	Context	Methods	Key findings
	<p>harmed in last 6 months.</p> <p>Recruited from the community (including a self-harm support group), through Child &amp; Adolescent Mental Health Service(CAHMS) and social care services.</p>	<p>psychology, mental health, and medicine. Young people represented on project advisory team. First Author: Academic with no clinical experience, nor experience or relationship with client group.</p> <p>Study funded by Dept. of Health Policy Research Programme.</p> <p>Study aim: provide insight into LAC CYP's experiences of self-harm, and of clinical services they received support from, to inform future service provision.</p>	<p>interviews.</p> <p>Data collected 2014-2015</p>	<p><i>Themes form 2nd order author interpretation:</i></p> <ul style="list-style-type: none"> <li>-changes in placement perceived as highly relevant to ideation and acts</li> <li>-feelings of anger strongly linked with SH, as a way of turning anger upon the self.</li> <li>-YP not wanting to talk or not feeling able to talk about SH and developing their own coping strategies.</li> <li>-experiences of clinical services varied, with some YP not feeling understood and others feeling supported – a mixed relational experience.</li> </ul>